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CENTE	RS FOR MEDICAR	TH AND HUMAN SERVICES RE & MEDICAID SERVICES			FOR	D: 02/21/200 M APPROVE O: 0938-039	
STATEMEN AND PLAN (	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIF A. BUILDING	PLE CONSTRUCTION	(X3) DATE	SURVEY LETED	
09G203		B, WING	<u> </u>	D2.	C /15/2008		
	ROVIDER OR SUPPLIER  JAL DEVELOPMEN		60	EET ADDRESS. CITY, STATE, ZIP CO 10 DIX STREET, NE ASHINGTON, DC 20019		10/2000	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
W 000	INITIAL COMMEN	VTS	W 000			<del>-</del>	
i i i i i i i i i i i i i i i i i i i	Administration (Do incident reports via and 28, 2008 from hospital emergency January, 2008. At three of the eight in had been hospitally January, 2008.  1. Review of unust 12, 2008 at approximate following:  a.) Client #1 was the room on January 4 that did not responding the hospital with a certain following.  b.) Client #1 was the emergency room on 7, 2008, for a product hospital with a certain following.  c.) Client #1 was the program to the hospital with a certain following and the hospital with a certain following following.  c.) Client #1 was the program to the hospital with a certain following following and following follo	ransported to the hospital n January uctive cough and admitted to diagnosis of pneumonia. Client from the hospital on January ansported from the day pital emergency room on or difficulty breathing and pital with a diagnosis of nd aspiratory pneumonia. harged from the hospital on insported to the hospital a January 6, 2008, because a blocked. Client #2 was overy gastric tube replacement			2009 MAR 10 A 10:38	RECEIVE DE MEALTH DEPARTMENT OF HEALTH HEALTH REGULATION ADMINISTRATION	
ORATORY D	MUJ MONTO	ERSUPPLIER REPRESENTATIVE'S SIGNAT	URE	1 RS	•	X6) DATE	

by deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that her safeguards provide sufficient protection to the patients. (See Instructions.) Except for nursing homes, the findings stated above are disclosable 90 days llowing the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 sys following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued

IRM CMS-2567(02-99) Previous Versione Obsoleto

Event ID: 9XM911

Facility ID: 09G203

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CENTERS FOR MEDICARE & MEDICAID SERVICES						FOR	D: 02/21/200 MAPPROVE
STATEMEN	IT OF DÉFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER;	(X2) M A. BU		IPLE CONSTRUCTION	(X3) DATE	O. 0938-039 SURVEY LETED
· · · · · · · · · · · · · · · · · · ·		09G203	B. WIN	IG _		000	C
	PROVIDER OR SUPPLIER  UAL DEVELOPMENT,	INC		6	REET ADDRESS, CITY, STATE, ZIP CODE 1010 DIX STREET, NE VASHINGTON, DC 20019		/15/2008
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL BC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	AOUILD BE	(X5) COMPLETION DATE
W 000	and released. [Note: Client #2's te	ge 1 emporary gastric tube was nanent gastric tube on	Wο	00			
	emergency room via an elevated tempera to he hospital with a	insported to the hospital 1911 on January 28, 2008, for liture. Client #3 was admitted diagnosis of sepsis. At the liton Client #3 remained in the					
	emergency room on 21, 2008, because howel sounds in all four quadrants and vissue like substance was approximately the was admitted to	e Was weak, had diminished					
, t	rebruary 8, 2008 for : scheduled right lapar tephrectomy and obe	oscopic radical in #4 was discharged from					
ro a fe	audo based on the ide elated to the facility's dequate services for emale with varying de	conducted February 12-15, entification of concerns capacity to furnish the three males and one grees of disabilities that The investigative findings	,		·		

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

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CENTE	RS FOR MEDICARE	E & MEDICAID SERVICES			OMB NO	<u>. 0938-0391</u>
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) ML A. BUIL	JLTIPLE CONSTRUCTION DING	(X3) DATE S COMPLI	
09G203		B. WIN	\$	02/1	C 5/2008	
NAME OF PROVIDER OR SUPPLIER INDIVIDUAL DEVELOPMENT, INC				STREET ADDRESS, CITY, STATE, ZIP CO 6010 DIX STREET, NE WASHINGTON, DC 20019		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
W 000 W 159	were based on obs and interviews with administrative staff investigations of un also conducted.	servations in the group home in residential, nursing, and f. Review of records; including nusual incident reports was	W 0		net as	
	integrated, coordin- qualified mental rel This STANDARD Based on interview Qualified Mental Re (QMRP) failed to e services for one of (Client # 3) The finding include The QMRP failed to recommended by the Client # 3 as evider	o obtain a gel mattress as he Physical Therapist (PT) for nced by:		As indicated in the report the gel mattress for client order at the time of the stagel mattress was received February 17, 2008. QMI ensure that all recomment followed and addressed it manner. QMRP will reverecommendations at least and provide ongoing stativia "Monthly Progress Nidentified recommendation	t findings t #3 was on arvey. The l on RP will dations are n a timely iew t monthly us reports ote" of the ons.	2.17.08 ongoing
	February 14, 2008 revealed that there top of a standard monsult dated Octol 2008 at approximal Client #3 had bilate status post coccyx revealed a recommodient #3. Interview 14, 2008 at approxime gel mattress had	ent #3's hospital bed on at approximately 3:30 PM was a foam mattress lying on nattress. Review of the PT ber 24, 2007 on February 14, tely 3:50 PM revealed that eral spastic quadriparesis and pressure ulcer, Further review nendation for a gel mattress for with the QMRP on February imately 4:00 PM revealed that ad been ordered a "few days o evidence that Client #3 had a		Routine QA reviews will conducted to further main compliance with this star	ntain	

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CENTE	RS FOR MEDICARE	AND HUMAN SERVICES  MEDICAID SERVICES				FOR!	D: 02/21/2008 MAPPROVED D: 0938-0391
STATEMEN AND PLAN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) A A, BU		TIPLE CONSTRUCTION	(X3) DATE : COMPL	SURVEY LETED
		09G203	B. WI	NG	· · · · · · · · · · · · · · · · · · ·	יוכח	C 15/2008
	PROVIDER OR SUPPLIER  UAL DEVELOPMENT,	INC			TREET ADDRESS, CITY, STATE, ZIP CODE 6010 DIX STREET, NE WASHINGTON, DC 20019	1 021	13/2000
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD 8F	(X5) COMPLETION DATE
W 159	gel mattress on his as recommended by 482.460(a)(3)(iii) Ph The facility must pro examinations of each includes routine screen	hospital bed y the PT HYSICIAN SERVICES  ovide or obtain annual physical th client that at a minimum	W				
	Based on staff intending facility failed to pay testing as determine for one of the four climinestigation. (Client The findings include:  1. Review of Client # dated December 27, at approximately 2:30 the client to have a unthe Licensed Practica 15, 2008 at approximately 2:30 that the urinalysis was recommended by the 2. Review of Client #2 27, 2007, on Februar 2:50 PM revealed an urine for culture and sinterview with the LPP approximately 2:55 P Client #3 did not have	3's physician's orders (POS) 2007, on February 15, 2008 D PM revealed an order for rinalysis. In an interview with al Nurse (LPN) on February nately 2:45 PM It was lient #3 did not have the med. There was no evidence s scheduled or obtained as physician. B's POS dated December y 15, 2008 at approximately order for the client to have a sensitivity obtained. In an N on February 15, 2008 at M It was acknowledged that					

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**2008** 

DEPAR CENTE	TMENT OF HEALTH RS FOR MEDICARI	H AND HUMAN SERVICES E & MEDICAID SERVICES	3			FOR	D: 02/21/200 M APPROVEI
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER;	; ,i	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION	(X3) DATE	<u>0. 0938-039</u> SURVEY LETED
		09G203		B. WING_			C
INDIVIDI	PROVIDER OR SUPPLIER  JAL DEVELOPMENT,		; <u>,</u>	6	REET ADDRESS, CITY, STATE, ZIP CODE 010 DIX STREET, NE VASHINGTON, DC 20019		15/2008
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHO (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	JUID BE	(X5) COMPLETION DATE
W 325	Continued From pa for culture and sens obtained as recomm	ge 4 Sitivity was scheduled or nended by the physician.		W 325	W325 This Standard will be met evidenced by:	as	
				:	The routine laboratory studictient #3 were completed as by the Primary Care Physici An annual laboratory scheduleveloped each year following individual's ISP and updated ordered by the Primary Care Physician. RN will continue monitor to ensure that all recommended laboratories stare completed in a timely mark.	ordered an.  tle is ng the l as to tudies anner.	2-20:08 ongoing
					as needed.		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CL IDENTIFICATION NUMBER			(X2) MULTI A. BUILDIN B. WING	PLE CONSTRUCTION G	(X3) DATE : COMPL		
09G203  NAME OF PROVIDER OR SUPPLIER STREET A					TATE TO GOOD	02/	15/2008
	JAL DEVELOPMENT		6010 DIX	STREET, NE STON, DC 20			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY LSC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
1 000	INITIAL COMMEN	NTS		1 000			
	Administration (DC incident reports via and 28, 2008, invorom visits In Januinvestigation three	of Health/Health Regul DH/HRA) received five a facsimile on January diving six hospital eme Jary, 2008. At the time of the eight residents been hospitalized withit 2008.	e unusual 4, 7, 23 rgency e of the residina				
	Review of unuse     2008 at approx     following:	ual incident reports on kimately 9:40 AM reve	February aled the				
	emergency room of 2008, for a product respond to medical	tive cough that did no	t .				,
	emerg≗ncy room o January 7, 2008, fo admitted to the hos	or a productive cough spital F Pneumonia. Resider e	and			·	
F	emergency room or January 23, 2008, productive cough at admitted to the hos Respiratory Failure	from the day program  nd  spital with a diagnosis  and  pnia. Resident # 1 was  hospital	for a				
	·	s transported to the h	ospital		÷		

ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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NAME OF PROVIDER OR SUPPLIER  INDIVIDUAL DEVELOPMENT, INC  STREET ADDRESS, CITY, STATE, ZIP CODE 6010 DIX STREET, NE WASHINGTON, DC 20019  (X4) ID PREFIX TAG  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 1  Emergency room on January 6, 2008, because her gastric tube was blocked. Resident#2 was treated and released with a temporary gastric tube.  [Note: Client #2's temporary gastric tube was replaced with a permanent gastric tube on January 14, 2008.]  e.) Resident #3 was transported to the hospital emergency room via 911 on January 28, 2008, for an elevated temperature. Resident #3 was admitted to the hospital with a diagnosis of sepsis. At the time of the	RVEY ED
INDIVIDUAL DEVELOPMENT, INC  (X4) ID SUMMARY STATEMENT OF DEPICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  (EACH CORRECTIVE ACTION SH	2008
PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION)    1 000   Continued From page 1   1 000	
emergency room on January 6, 2008, because her gastric tube was blocked. Resident#2 was treated and released with a temporary gastric tube.  [Note: Client #2's temporary gastric tube was replaced with a permanent gastric tube on January 14, 2008.]  e.) Resident #3 was transported to the hospital emergency room via 911 on January 28, 2008, for an elevated temperature. Resident #3 was admitted to the hospital with a diagnosis of	(XS) COMPLETE DATE
January 6, 2008, because her gastric tube was blocked. Resident#2 was treated and released with a temporary gastric tube.  [Note: Client #2's temporary gastric tube was replaced with a permanent gastric tube on January 14, 2008.]  e.) Resident #3 was transported to the hospital emergency room via 911 on January 28, 2008, for an elevated temperature. Resident #3 was admitted to the hospital with a diagnosis of	-
replaced with a permanent gastric tube on January 14, 2008.]  e.) Resident #3 was transported to the hospital emergency room via 911 on January 28, 2008, for an elevated temperature. Resident #3 was admitted to the hospital with a diagnosis of	
emergency room via 911 on January 28, 2008, for an elevated temperature. Resident #3 was admitted to the hospital with a diagnosis of	
investigation Resident #3 remained in the hospital.	
f.) Resident #4 was transported to the hospital emergency room on January 21, 2008, because he was weak, had diminished bowel sounds in all four quadrants and vomited a blood stained tissue like substance that was approximately three centimeters long. Resident #4 was admitted to the hospital for vomiting and was discharged from the hospital on January 28, 2008.	
[Note: Resident #4 was admitted to the hospital on February 8, 2008 for a scheduled right laparoscopic radical nephrectomy and cystolithotomy. Resident #4 was discharged from the hospital on February 12, 2008.]	
An investigation was conducted February 12-15, alth Regulation Administration	

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE		1 '	TIPLE CONSTRUCTION		(3) DATE SU COMPLE	
		09G203		A. GÜİLDII B. WING	NG	· ·	C' 02/15/2008	
NAME OF F	PROVIDER OR SUPPLIER		STREET ADD	DRESS, CITY,	STATE, ZIP CODE	_ · _	<u> </u>	12000
INDIVIDUAL DEVELOPMENT, INC 6010 to WASH				STREET, N TON, DC 2	: E	,		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	ON SHOULD	OBE 🐪	(X5) COMPLETE DATE
000 1	Continued From page	ge 2		1 000			-	
	2008 based on the related to the facility adequate services f female with varying resided in this facilit are based on observand interviews with administrative staff. Investigations of unualso conducted.	's capacity to furnish for the three males a degrees of disabilitie y. The investigative vations in the group residential, nursing, Review of records; usual incident reports	nd one and one set that findings home and including s was				-	
1 395	3520.2(e) PROFESS PROVISIONS			1 395				
	Each GHMRP shall professional staff to necessary professional accordance with the individual habilitation necessary by the interprofessional services limited to, those services trained, qualified, and District of Columbia disciplines or areas of	carry out and monitorial interventions, in goals and objectives oplan, as determined erdisciplinary team. Is may include, but notices provided by indications of the following the required win the following	or s of every d to be The ot be lividuals					
	(e) Nursing;			,				
	This Statute is not make the GHIMRP failed to professional staff car necessary profession accordance with clier objectives of every indetermined to be necessary the investigation. (Rother findings include:	o ensure that qualified out and monitor nal interventions, in onts needs, the goals dividual habilitation pessary by the offer one of four resident#3)	ed red s and plan, as					-
rate Form	tion Administration	·	6800	9)	KM911		lf continuation	sheet 3 of 5

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STATEMENT OF DEFICIENCIES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A: BUILDING B. WING 09G203 02/15/2008 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 6010 DIX STREET, NE INDIVIDUAL DEVELOPMENT, INC WASHINGTON, DC 20019 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX TAG REGULATORY OR LSC (DENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) 1395 1395 Continued From page 3 1. Review of Resident #3's physician's orders (POS) dated December 27, 2007, on February 15, 2008 at approximately 2:30 PM revealed an order for the client to a urinalysis. In an interview with the Licensed Practical Nurse (LPN) on Reference response to W325 of the 2·20·08 February 15, 2008 at approximately 2:45 PM it Federal Deficiency report. ongoing was acknowledged that Resident #3 did not have the laboratory test performed. There was no evidence that the unnalysis was scheduled or obtained as recommended by the physician. 2. Review of Resident #3's POS dated December 27, 2007, on February 15, 2008 at approximately 2:50 PM revealed an order for the client to have a urine for culture and sensitivity obtained, in an interview with the LPN on February 15, 2008 at approximately 2:55 PM it was acknowledged that Resident #3 did not have the laboratory test performed. There was no evidence that the urine for culture and sensitivity was scheduled or obtained as recommended by the physician. 1422 3521,3 HABILITATION AND TRAINING 1422 Reference Response to W159 of the 2-17:08 Federal Deficiency report. Each GHMRP shall provide habilitation, training ongoine and assistance to residents in accordance with the resident 's Individual Habilitation Plan This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to ensure habilitation, training and assistance was provided for one of four residents. in the investigation in accordance with their Individual Habilitation Plan (IHP). (Resident #3) The finding includes: The QMRP falled to obtain a gel mattress as recommended by the Physical Therapist (PT) for

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  DEFICIENCIES AND PLAN OF CORRECTION  DEFICIENCIES AND PLAN OF CORRECTION  DEFICIENCIES AND PROVIDER/SUPPLIER/GLIA IDENTIFICATION NUMBER:  09G203		A. BUILDIN B. WING _					
	PROVIDER OR SUPPLIER UAL DEVELOPMENT,	INC	6010 DIX	DDRESS, CITY, S STREET, NE GTON, DC 20	STATE, ZIP CODE 0019		<u> </u>
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES		FIN I	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHO (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	710000	(X5) COMPLET DATE
	Continued From page Resident # 3 as evident # 3 as evident # 2008 a revealed that there was not top of a standard consult dated Octobe 2008 at approximate Resident #3 had bills and status post coordinate review revealed a remattress for Resident #3 had bills ordered a "few days that Resident #3 had hospital bed as recordinated as re	dent #3's hospital beat approximately 3:30 was a foam mattress mattress. Review of er 24, 2007 on February 3:50 PM revealed the approximation for a series a	o PM coverlay fithe PT uary 14, I that paresis urther gel the nately ad been evidence	1 422			